Analysis of Family Planning / HIV/AIDS Integration Activities within the USAID Population, Health and Nutrition Center

Results of a Survey Conducted by
Advance Africa and
The CATALYST Consortium

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List of Abbreviations

AA/CC Team	Advance Africa / CATALYST Consortium Team
AIDS	Acquired Immunodeficiency Syndrome
ANE	Asia and the Near East Region
BCC	Behavior Change Communication
CA	USAID Cooperating Agency
DP	Dual Protection
E&E	Europe and Eurasia Region
FP	Family Planning
FY	Fiscal Year
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
LAC	Latin America and the Caribbean Region
MTCT	Mother-to-Child Transmission
NGO	Non-Governmental Organization
PHN	USAID Population, Health and Nutrition Center
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

EXECUTIVE SUMMARY

As HIV/AIDS becomes more prevalent in all parts of the world, it is imperative to explore innovative ways to prevent its further spread and to treat those who are already infected. One strategy that has come to light is the integration of HIV/AIDS and reproductive health services. If effective, this strategy will increase the availability of both HIV/AIDS and reproductive health services, potentially making all of these services more cost-effective and more holistic.

As a first step in determining the efficacy of this strategy, USAID's Population, Health and Nutrition Center (PHN) asked Advance Africa and the CATALYST Consortium to conduct a survey to identify what types of integration activities are already in place. Twenty-five agencies responded to the survey, which was conducted in late 2001.

Results of the survey show that USAID has invested well over $200 million in just four years. About half of this has been channeled through bilateral programs, one-third through field support and 14% through core funding. Other donors to these 25 agencies have contributed $120 million over the four years. The agencies report 95 dual protection projects and 129 integration projects.

The majority of integration and dual protection projects work in the Africa, the region most affected by HIV/AIDS. Many fewer are working in Asia and the Near East and Europe and Eurasia, two regions where HIV infections rates are beginning to soar. Thus far, most projects have focused their work on communication, training and education, with much less attention to strategies such as voluntary counseling and testing, mother-to-child transmission and policy.

The focus of dual protection and integration projects thus far has been on working with general populations (family planning and maternal and child health clients, and their partners), rather than specific high-risk groups. Those projects that work with youth work about equally with in-school and out-of-school populations.

Dual protection projects unanimously promote the use of condoms for both infection prevention and pregnancy prevention. Fewer of these projects promote other dual protection strategies such as condoms plus another contraceptive, mutual monogamy or abstinence. Over the four years covered by the survey, the 25 responding agencies will have distributed over 1.8 billion condoms for dual protection, very few of which are female condoms.

Integration projects are heavily influenced by the work of Population Services International, which implements almost half of the reported integration activities. Projects use about equally the two integration strategies: integration of HIV into existing family planning services, and integration of family planning into existing HIV services. When PSI is excluded from this calculation, however, the majority of the projects integrate HIV into existing family planning services. Most of the integration projects are carried out in the community.

Almost three-quarters of the dual protection and integration projects use monitoring and evaluation systems. The data they collect for this purpose focuses mainly on knowledge, attitudes and practices, and somewhat less on capacity and sustainability.

The 25 organizations report that institutional factors (personnel issues and lack of materials) are among the major barriers to the success of dual protection and integration projects, followed closely by community, cultural and religious factors. Factors that enable the success of these projects are mainly related to commitment, collaboration and stakeholder involvement, along with service provision.

Although it was not within the scope of this survey to assess the efficacy of integration as a strategy for combating HIV/AIDS, the results can be used as a basis such investigation in the future. The survey can also be shared with other donors and be used for collaborative planning to address the global spread of HIV/AIDS.

I. INTRODUCTION

The spread of HIV/AIDS through the developing world has had a devastating effect not only on health but on overall economic development as well. By targeting young people, HIV/AIDS has seriously reduced the productive populations in some countries, quickly reversing many years of development.

The United States Agency for International Development (USAID) is one of many development agencies seeking to stop the spread of HIV/AIDS using strategies ranging from providing information and education, to providing prevention and care services. Recently, the integration of family planning/reproductive health services and HIV/AIDS services has been viewed as a potentially effective strategy for reaching greater numbers of people in more holistic service settings. The efficacy of this strategy, however, has not been sufficiently documented, nor has the scope of its use throughout the world.

In order to better understand the potential for integration as an effective strategy to combat HIV/AIDS, the USAID Intra-agency FP/HIV/AIDS Integration Working Group decided to survey the array of cooperating agencies (CAs) that often work with USAID. After an informal survey conducted in February 2001 resulted in inconsistent information, the Working Group determined that a more formal survey of CAs was necessary to identify the magnitude and scope of integration work. The information gathered in the survey would help USAID in developing strategies to address the threat of HIV/AIDS more effectively and efficiently. Toward this end, the Working Group requested the assistance of Advance Africa and the CATALYST Consortium in carrying out such a study.

The goal of the survey was for the Working Group to gain an overall understanding of the number and scope of FP/HIV/AIDS integration activities, including dual protection, conducted by USAID's Population, Health and Nutrition Center (PHN) cooperating agencies. Analysis of findings would enable USAID to better identify gaps and appropriate and non-appropriate activities as well as gain insight into potential best practices in FP/HIV/AIDS Integration.

II. METHODOLOGY

In proceeding with the survey, the Integration Working Group, with feedback from Advance Africa and CATALYST (AA/CC Team), developed definitions of dual protection and integration that expressed USAID's current understanding of the terms. These definitions were included in the survey in several places to ensure that respondents were cognizant of specific activities to be reported:

> ***Dual Protection:*** Protection from both pregnancy and STI/HIV through: use of male/female condom; abstinence; avoidance of penetrative sex; the use of a contraceptive method plus mutual monogamy among uninfected partners; or through use of a condom plus another contraceptive method.
>
> *Specific Definitions of the Four Dual Protection Strategies:*
>
> - Use of male or female condom for both infection prevention and unwanted pregnancy.
> - Abstinence or avoidance of all types of penetrative sex.
> - Use of contraceptive method with mutual monogamy among uninfected partners.
> - Use of male or female condom for infection prevention (including during pregnancy) AND use of another method of contraception.
>
> ***Integration:*** "[D]elivering two or more types of services previously provided separately, as a single, coordinated, and combined service."[1] These activities and/or services include the integration of family planning and reproductive health activities with HIV/AIDS activities such as: voluntary counseling and testing (VCT), syndromic management and non-syndromic management of sexually transmitted infections (STI), mother-to-child transmission (MTCT), HIV/AIDS care, behavior change communication (BCC), counseling, contraceptive provision, etc.

With input from the AA/CC Team, the Working Group used these definitions to draft matrices to ensure that data collected from CAs were quantifiable and comprehensive. These matrices were then used as the basis for the design of the survey instruments. The survey was developed as a Microsoft Access database in order to streamline the data collection and analysis.

The survey consisted of three questionnaires (see Annex 1). The first included general organizational information, including the funding that the organizations disbursed for the implementation of dual protection and integration activities. The questions regarding USAID funding were broken down by fiscal year (FY1999 – FY2002) and source (core funds, bilateral funds, and field support funds). Organizations were also asked to provide information about other donor funds that were being used for integration activities. This included the name of the donor and the collective total for the four fiscal years.

The second questionnaire related specifically to dual protection projects. Respondents were asked to answer questions based on the definition of dual protection that was provided in the form. The questionnaire solicited information related to the strategies through which activities were

[1] "What do we mean by Integration?" *The Manager*, VII(3). Boston, MA: Management Sciences for Health, Fall 1998.

implemented, countries of activity, types of activities, clients served, male and female condom distribution, monitoring and evaluation, and barriers and enabling factors for implementation. In most questions, participants were asked to check all responses that applied to the project, resulting in the possibility of multiple responses and totals of over 100% in the results section. The questions related to monitoring and evaluation and to barriers and enabling factors were open-ended, so respondents typed in their answers.

The third questionnaire related to integration projects. Respondents were asked to answer questions based on the definition of integration that was provided in the form. Respondents answered general questions about each integration project (eg. goal, countries of activity), and then entered information about each specific activity in a sub-form. The sub-form asked questions related to the strategies through which activities were implemented, geographic context, organizational context, programmatic context, and clients served. After all of the project's activities were entered in individual sub-forms, respondents answered open-ended questions about monitoring and evaluation and barriers and enabling factors for the project as a whole. Again, multiple responses were possible for most questions.

The survey as a whole did not include any questions on the impact of activities, nor did it strive to measure quality or effectiveness of integrated services.

The AA/CC Team pilot tested the survey with two CAs. Based on their experiences with the database questionnaire and subsequent discussions with the Integration Working Group, changes were made in both design and content. An effort was made to design the survey in the most user-friendly fashion to allow for a quick response time.

The survey was distributed by e-mail from Duff Gillespie, Deputy Assistant Administrator of the Bureau for Global Health to over 70 CAs from the PHN User's Guide[2] on September 19, 2001. Attached to the e-mail were the survey instructions and the Access database as well as the person to contact for hard copies of the survey questionnaires, if needed. The e-mail message requested that responses be returned by October 12, 2001 to the AA/CC Team, although responses were received as late as February 22, 2002. Members of the Integration Working Group, Advance Africa, and CATALYST followed up with various CAs to ensure that as many as possible responded to the survey, even to express that they did not have any integration activities.

As completed database questionnaires were received, the AA/CC Team imported the data into a compiled Access database. Some responses were received either on paper or in Microsoft Word documents and this information was manually entered into the database.

Once data collection was complete, the AA/CC Team analyzed the data within the Access database. Analysis consisted mainly of frequencies and some cross tabulations. Responses to the open-ended questions were exported and analyzed in Microsoft Word.

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[2] *User's Guide to the USAID/Washington Population, Health and Nutrition Programs*, January 2001.

III. RESULTS

The AA/CC Team received responses from 25 organizations, 18 of which implement activities in dual protection and/or integration. Organizations that responded to the survey included the following:

- Abt Associates
- Academy for Educational Development (AED)
- CARE
- CEDPA
- Deloitte Touche Tohmatsu
- EngenderHealth
- Family Health International
- The Futures Group International
- The JHPIEGO Corporation
- Johns Hopkins University Center for Communication Programs (JHUCCP)
- John Snow, Inc. (JSI)
- LTG Associates
- Macro International
- Management Sciences for Health (MSH)
- The National Institutes of Health (NIH) Fogarty International Center
- Pathfinder International
- The Population Council
- Population Reference Bureau (PRB)
- Population Services International (PSI)
- Save the Children
- University of North Carolina, Carolina Population Center
- University of Michigan School of Public Health
- US Bureau of the Census, International Program Center
- US Peace Corps
- World Health Organization

The Gates Foundation also responded to the survey, but the data were not included in the analysis because the data were incomplete and duplicated what was reported by the Foundation's grantees. The agencies reported a total of 95 dual protection projects and 129 integration projects, with 441 integration sub-activities.

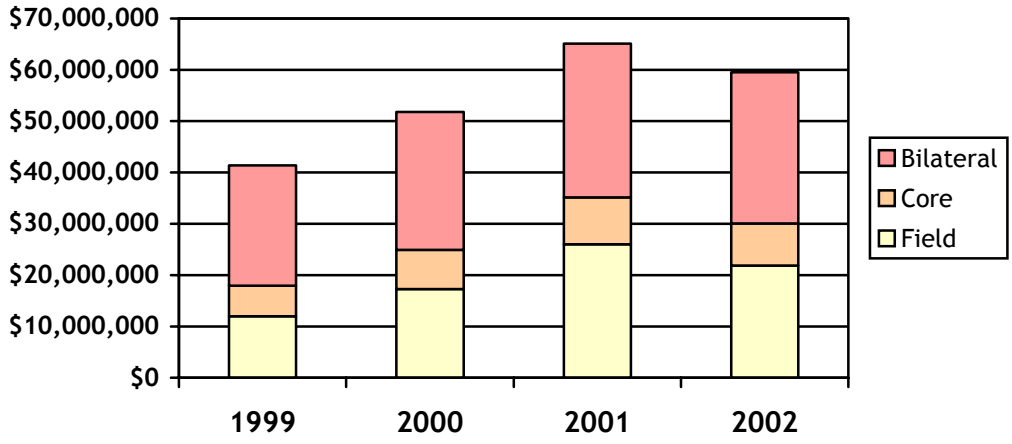
Funding

The 25 responding organizations provided information on the amount of funding spent on integration and dual protection activities combined. The data were not broken down by project, activity, or by integration vs. dual protection. Respondents reported on USAID core, bilateral, and field funding for fiscal years 1999 through 2002 – four years in total. Funding for FY2002 was projected. The respondents could also list the names of up to two other donors, as well as the four-year amount of funding received from those donors.

Total USAID funding for integration and dual protection for FY1999-FY2002 is $217,786,013. Of this, $109 million is bilateral funding, $77 million is field funding, and $31 million is core funding.

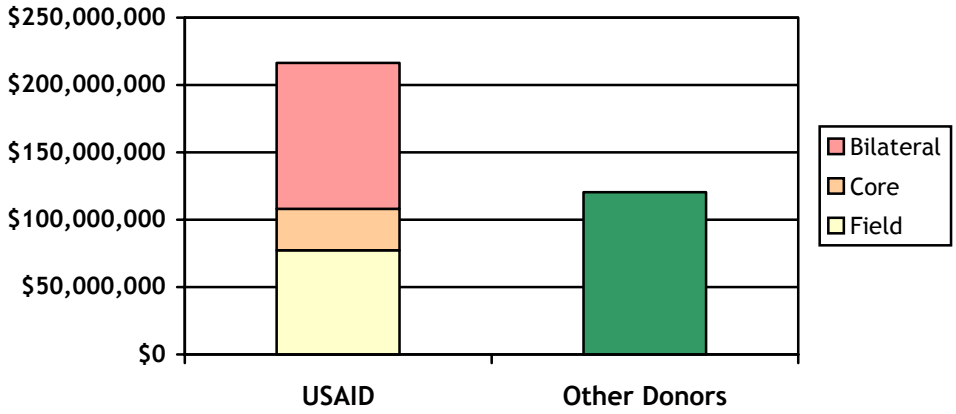
USAID field support funding increased over the course of the four years, from 29% to 37% of total USAID funding. Core funding has remained relatively stable at approximately 14%, while bilateral funds have decreased from 57% to 49% of total USAID funding.

Figure 1: USAID Funding for Dual Protection and Integration
25 Organizations Responding
Total USAID Funding = $217,786,013



When funding from other donors is taken into account, the total funding for integration and dual protection activities is $338,173,013. Other donors provided over $120 million, which accounts for more than one third of the total. This is approximately the same amount as all bilateral funds.

Figure 2: Total Funding for Dual Protection and Integration
25 Organizations Responding
Total Funding = $338,173,013
Total USAID Funding = $217,786,013



It is important to note that $118 million of the $120 million other donor funds were given to Population Services International (PSI), representing 47% of that organization's total funding for integration and dual protection activities. PSI received 60% of all of the USAID funds and 74% of all funding (both USAID and other donors) reported here.

The British Department for International Development and the German KfW Group provided the majority of the other donor funding ($80 million and $38 million respectively). Additional donors

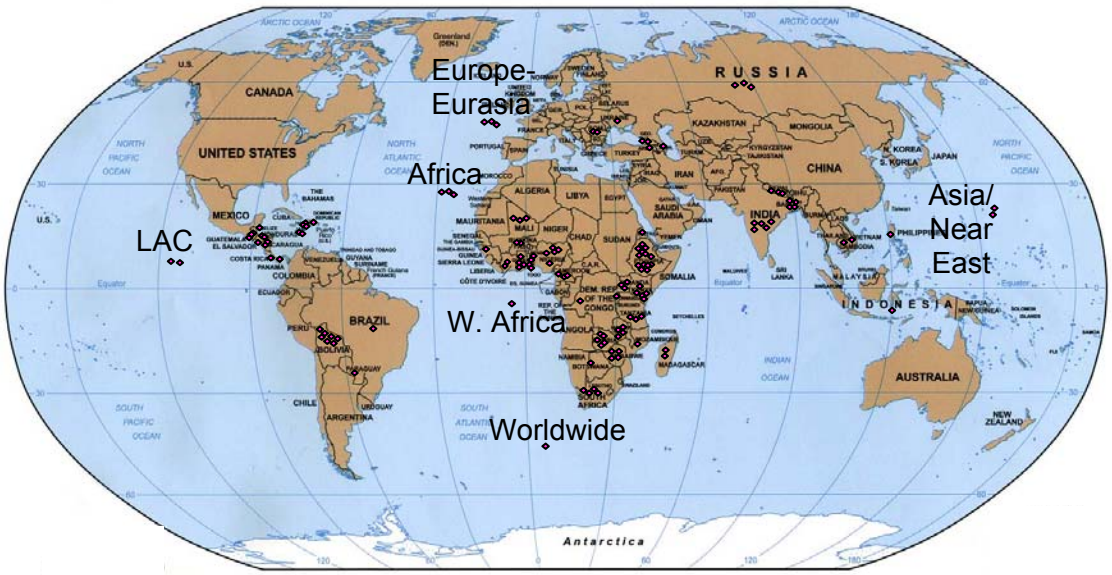
include the Packard Foundation, the Gates Foundation, the Compton Foundation, the Summit Foundation, the World Health Organization and the US Department of Health and Human Services' Health Resources and Services Administration.

Dual Protection

The 25 responding agencies reported 95 dual protection projects, approximately 30% of which are implemented by Population Services International. Many of the projects work in more than one country or region, but the majority are being carried out in Africa (86%), with substantially fewer in Latin America and the Caribbean (26%), Asia and the Near East (19%), and Europe and Eurasia (13%). There are also eleven regional projects and one global project.

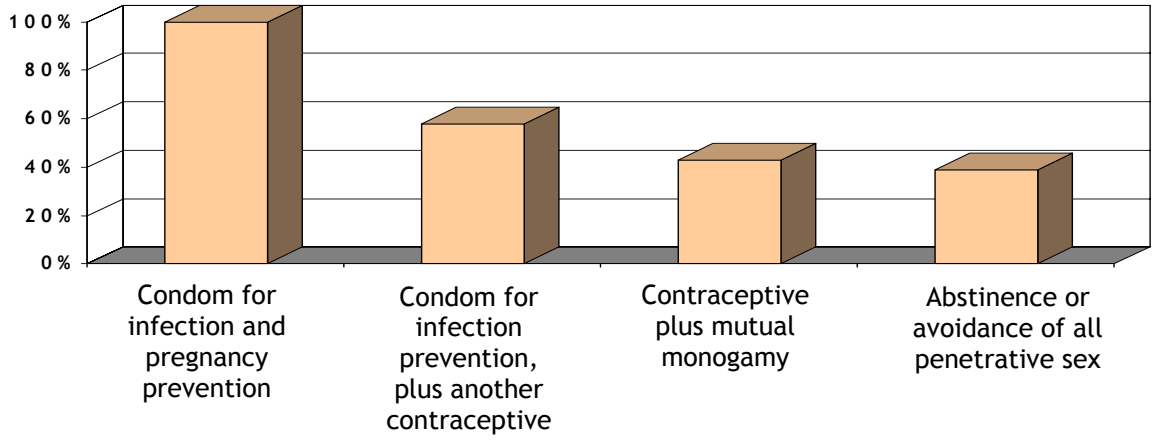
Figure 3: Location of Dual Protection Projects

25 Organizations Responding
95 Projects



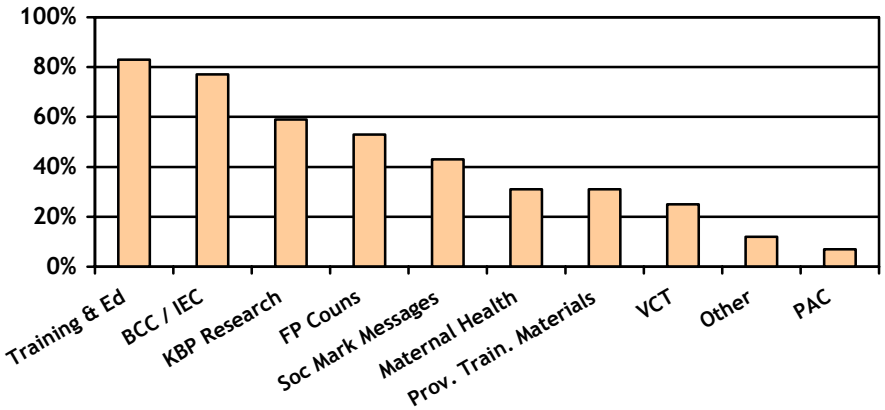
All 95 projects report promoting dual protection through use of the male or female condom for prevention of both infection and unwanted pregnancy. Significantly fewer projects are promoting the other three dual protection strategies, particularly "abstinence or avoidance of all penetrative sex," which is promoted the least in all regions except Africa, where a contraceptive plus mutual monogamy is promoted less.

Figure 4: Dual Protection Strategies Used
25 Organizations Responding
95 Projects



Program managers of the 95 projects are using fairly standard types of activities to promote dual protection. For example, over 80% of the projects are conducting training and/or orientation for health workers, clients and/or communities. Other common types of activities include behavior change communication (78%); research related to knowledge, behavior and practices (59%); and family planning counseling (53%). Somewhat less common are social marketing messages, maternal health and provider training materials or curriculum development. Promotion of dual protection as part of voluntary counseling and testing (VCT) or postabortion care (PAC) is much less common. This is most likely due to the fact that VCT and PAC are relatively new strategies. Some projects are promoting dual protection through a variety of "other" types of activities, including gender, immunization, breastfeeding, advocacy, policy, STI management, and operations research activities.

Figure 5: Dual Protection Activities
25 Organizations Responding
95 Projects

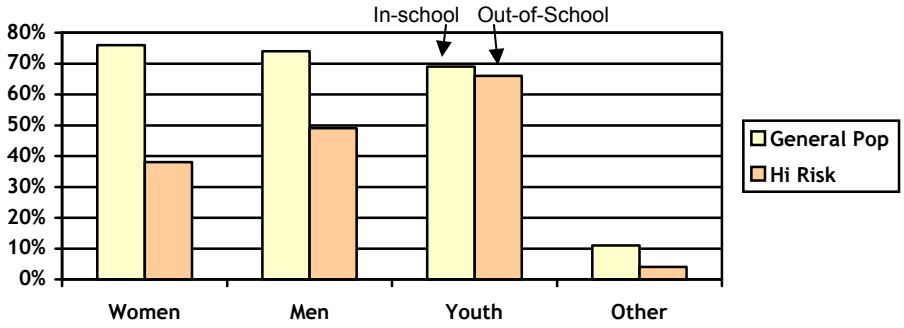


The 95 dual protection projects are working for the most part with general population groups such as maternal and child health and family planning clients (83%), and their partners or spouses (75%). Significantly fewer projects work with high-risk groups such as commercial sex workers (33%), truck

drivers (20%), military/police (9%), men who have sex with men (9%) or intravenous drug users (1%). Respondents listed a variety of "other" women, men, and youth that they serve, and these have been categorized as either general population or high-risk and included in the existing categories. Respondents also listed general "other" populations that include adult caregivers, children, cross-generational sexual partners, migrants, indigenous, and partners in "sweetheart" relationships. These have been categorized as "other – general population" or "other – high-risk."

Figure 6: Targets Population of Dual Protection Activities

25 Organizations Responding
95 Projects



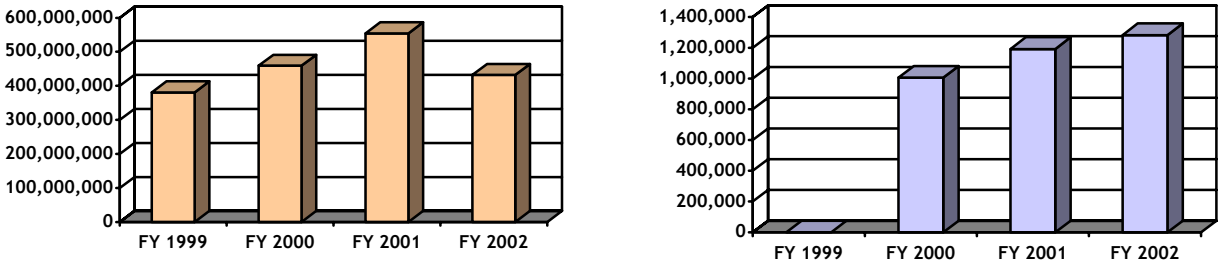
Dual protection projects for young people work almost equally with in-school youth and out-of-school youth. Projects working with other youth populations make up a small portion of all of the projects and include, for example, black youth, children under 5, commercial sex workers, and university/college students.

Thirty-three projects only work with adults and five projects only work with youth. Only one project works solely with high-risk adults, as opposed to general population adults. There are no projects that work solely with in-school youth or solely with out-of-school youth.

Condoms are a key component of dual protection promotion. Survey results show that 68% of the 95 projects distribute condoms. Over the four years covered by this survey (1999 – 2002), over 1.8 billion male and female condoms will have been distributed for dual protection by the agencies responding to the survey (additional condoms may have been distributed for other purposes). Of these, almost all are male condoms, and Population Services International (PSI) distributes the majority of them (90%), with most of the remaining 10% distributed by JHPIEGO, Deloitte Touche Tomahtsu and Pathfinder.

Figure 7: Male and Female Condom Distribution

25 Organizations Responding
95 Projects
Male Condoms = 1,825,884,373
Female Condoms = 3,479,714



The 25 responding agencies report an increase in distribution of male condoms from 1999 through 2001. Reported distribution seems to drop in 2002, but this may be because the figures submitted are estimates rather than based upon actual data.

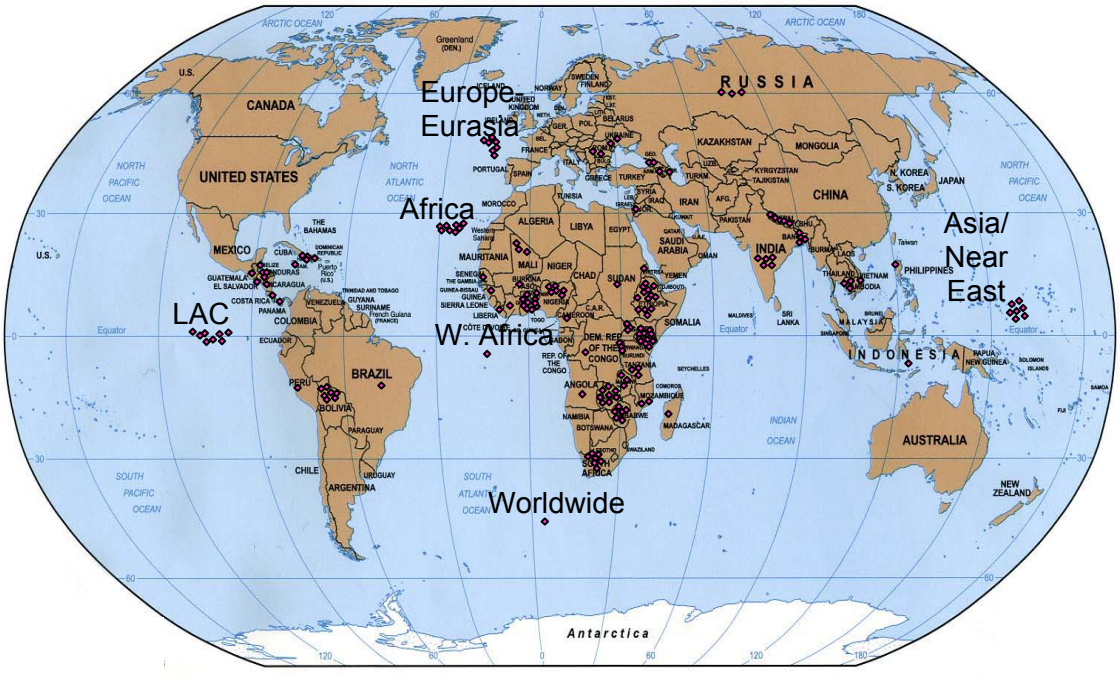
Over the four years, 3.5 million female condoms will have been distributed, with an increase each year. In 1999, no female condoms were distributed by these agencies for the purpose of dual protection, though they may have been distributed for other purposes. Only three agencies are involved in distribution of female condoms – PSI, Pathfinder and CEDPA. Almost all of the female condoms were distributed by PSI.

Integration

The Integration questionnaire was slightly different from the Dual Protection questionnaire in that respondents filled out a separate sub-form for each activity carried out within one project. It is important to note that just as PSI's response greatly influenced the funding data, PSI has a large impact on the integration data, as it implements 43% of the 441 reported integration activities.

The 25 organizations reported 129 projects reporting 441 integration activities. Similar to dual protection, the majority of integration activities are implemented in Africa (88%), although there are various projects throughout Latin America and the Caribbean (25%), Asia and the Near East (23%), and Europe and Eurasia (14%). Agencies are implementing more regional and global activities for integration than for dual protection (32 regional and 2 global).

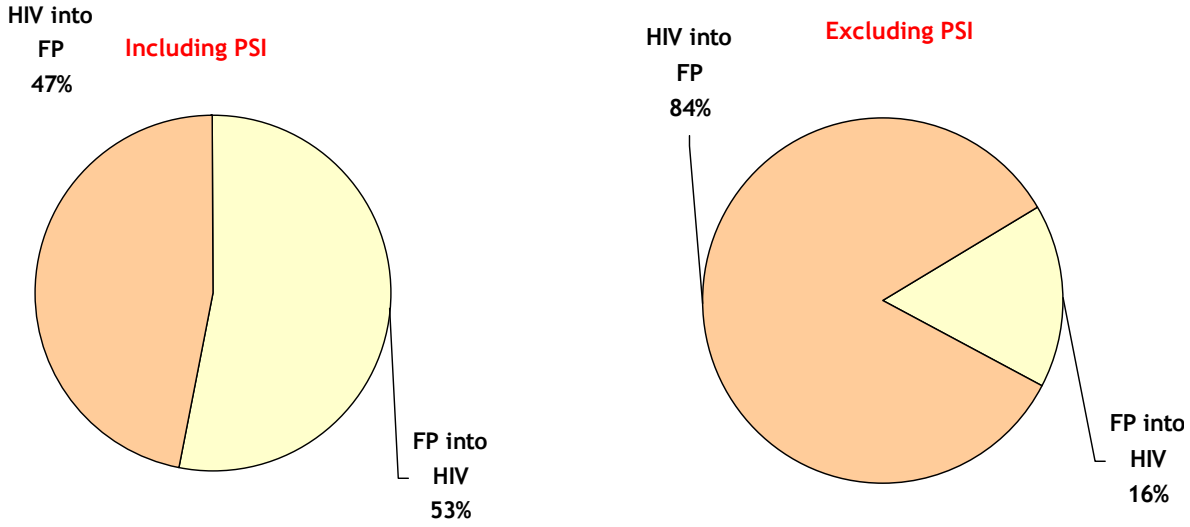
Figure 8: Location of Integration Projects
25 Organizations Responding
129 Projects



The survey asked respondents to report their main strategy for implementing integrated activities. Of the 441 activities, 53% integrate family planning into existing HIV programs. This is strongly influenced by the fact that a large portion of PSI's activities use this strategy. When PSI data are excluded, most of the activities (84%) are integrating HIV into existing family planning programs.

Figure 9: Integration Strategies Used within Activities

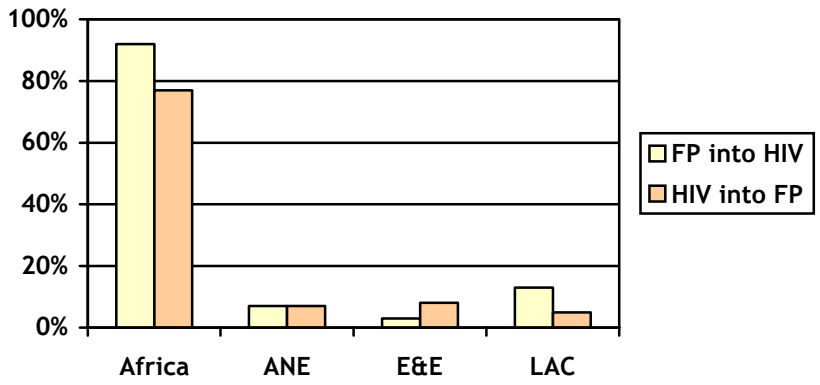
25 Organizations Responding
129 Projects
441 Sub-Activities



When broken down by region, more activities in Africa and LAC integrate family planning into existing HIV programs. Activities in Asia and the Near East and Europe and Eurasia, however, lean in the opposite direction, focusing more on integrating HIV into family planning programs. Again, these results are influenced by the fact the PSI does most of its work in Africa and LAC and mainly integrates FP into HIV.

Figure 10: Integration Strategies by Region

25 Organizations Responding
129 Projects
441 Sub-Activities



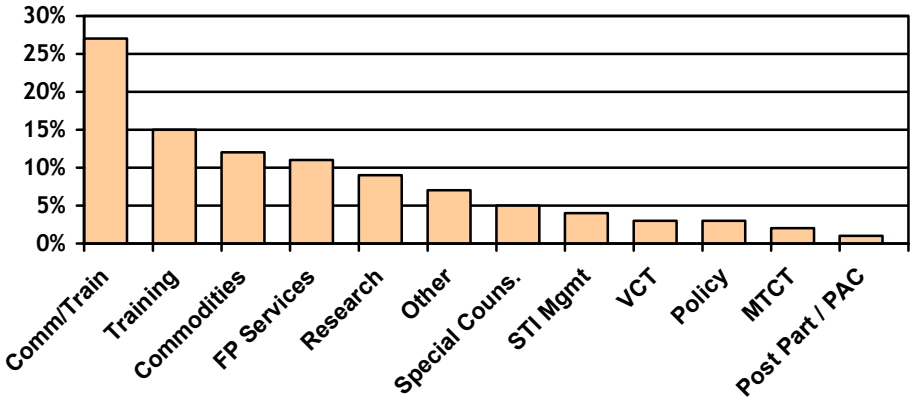
In exploring the project activities, the integration results are similar to those of dual protection – common program components and channels are utilized as the conduit for integrated activities. Unlike the dual protection questionnaire, however, the integration questionnaire solicited more specific information about the types of activities being implemented.

The most common integration activities relate to Communication/Training (27% of all 441 activities). Almost half (47%) of these Communication/Training activities relate to IEC and interpersonal relations, 31% are behavior change communication and social marketing work, 16% focus on peer education, personal communication, and negotiation, and 5% work with the media. (See the questionnaires in Annex 1 for list of subcategories).

Other types of Training activities make up 15% of all of the 441 activities. These include mainly in-service training and training FP staff in HIV and, less frequently, training of FP staff on MTCT and VCT, and training of HIV staff on FP.

Twelve percent of the 441 integration activities relate to Commodities, mainly on male condoms (67%) and female condoms (23%). Commodities activities also include work promoting integration along with STI kits, oral rehydration salts and bednets.

Figure 11: Integration Activities
25 Organizations Responding
129 Projects
441 Sub-Activities



Family Planning Service Delivery, which accounts for 11% of integration activities, includes contraceptive provision (65%), counseling on family planning (18%), referral for family planning (12%), and VCT alone or with pre/post-test counseling (5%).

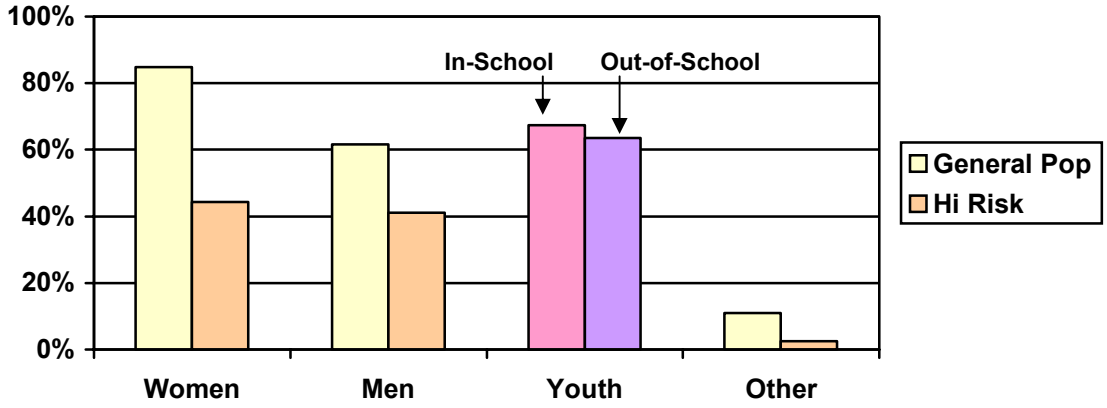
Research makes up 8% of integration activities. Operations research represented 97% of these activities while only one project reported any type of biomedical research.

Other types of activities, such as capacity building, delivery of other types of services, and food security, were reported in much smaller numbers than the activities listed above, along with specialized counseling, STI management, VCT, policy, MTCT and post-partum/PAC.

As with the dual protection activities reported, the 441 integration activities focus mainly on the general population among adults, and work equally with in- and out-of-school youth. Those represented in the "other" category include children, NGOs, providers, professional associations, and port workers and other specific high-risk groups.

Figure 12: Target Population of Integration Activities

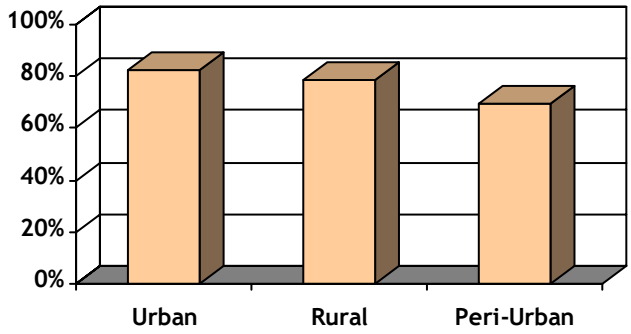
25 Organizations Responding
129 Projects
441 Sub-Activities



Unlike the dual protection questionnaire, the integration questionnaire asks about the geographic, organizational and programmatic context in which each activity is implemented. Respondents were able to select all that applied to their activities resulting in percentages adding to more than 100%. Related to geographic context, the 441 activities are working almost equally in urban (82%) and rural areas (78%), and slightly less frequently in peri-urban areas (69%).

Figure 13: Geographic Context of Integration Activities

25 Organizations Responding
129 Projects
441 Sub-Activities

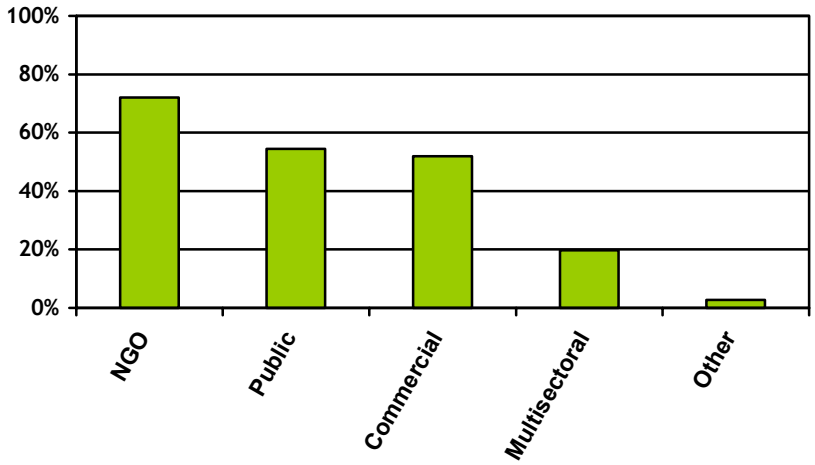


Integration projects are mainly implementing their activities through NGOs (72%), the public sector (54%), and the commercial sector (52%). Almost half of the NGOs work in the area of family planning and one-third work on HIV/AIDS, with faith-based organizations making up the

remaining 20% of NGOs. Within the public sector, family planning agencies implement 61% of activities and HIV/AIDS organizations implement 39%. Due to the large number of condoms being distributed and sold and the high percentage of commodities activities, it is likely that the activities implemented in the commercial sector are largely related to commodities. Again, PSI's data has a substantial impact on this area.

Figure 14: Organizational Context of Integration Activities

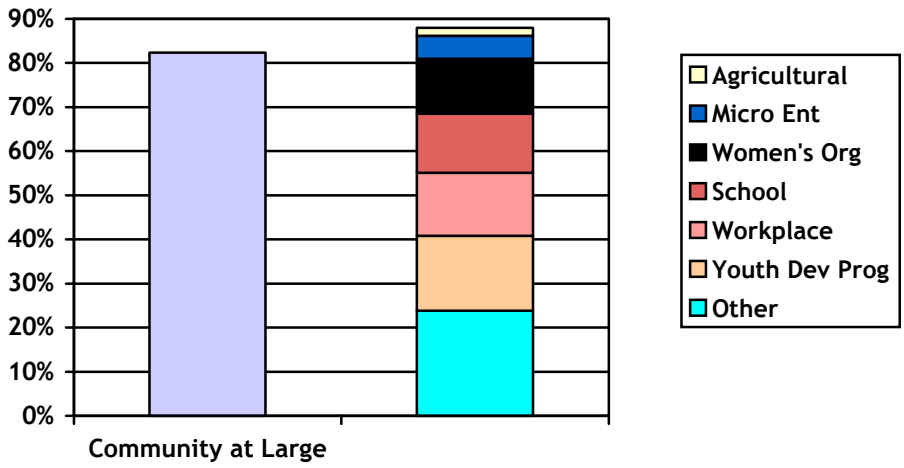
25 Organizations Responding
129 Projects
441 Sub-Activities



The overwhelming majority of projects report implementing activities in the community. Many respondents likely marked that their activities were implemented in the community and also marked another option to specify a more specific context within the community.

Figure 15: Programmatic Context of Integration Activities

25 Organizations Responding
129 Projects
441 Sub-Activities



The "other" program context category includes community distribution agents, health facilities and clinics, outreach, military, government, political and traditional leaders, and religious institutions.

Monitoring and Evaluation, and Barriers and Enabling Factors

Both the dual protection and integration questionnaires ask about monitoring and evaluation (M&E) systems. Approximately 70% of the projects report using some sort of M&E system. Most of those with M&E systems provided information on the types of indicators for which they are collecting data, but because of some confusion about the difference between process and outcome indicators, the two lists have been combined (see Annex 5). The 1,028 individual indicators have been organized into categories.

The most common indicators for which data are being collected relate to knowledge, attitudes and practices (244 indicators). These included, for example, use/demand of condoms, number of partners, risk perception, knowledge of HIV, awareness, number of clients educated about FP/HIV, and knowledge/attitudes about condoms. Indicators related to capacity and sustainability were also common and included number of providers trained and project cost efficiency. The third most frequent category of indicators was access to condoms and services, and includes numbers of condoms distributed and sold and number of NGOs distributing them, among others. Other indicators relate to family planning use; information, education and communication materials; and the quality of clinical services.

A variety of factors are listed as barriers to the success of dual protection and integration projects and these are categorized for ease of analysis (see Annex 6). Most common among the 300 barriers listed are institutional factors (85). This includes personnel issues (training, experience, commitment, attitudes) and lack of materials and job aids. Community, cultural, and religious factors are also listed as common barriers to project success (66). These include stigma, conservativeness, and cultural values around sex. Individual factors are also mentioned as barriers to success (36). This category includes, for example, lack of awareness, understanding and perceived threat, and the desire to have children. Developmental/environmental issues (30), including low literacy and education levels as well as conflict and unrest on a national level, are additional barriers to project success. Economic/financial barriers (23) such as funding limits and poor economy also influence project success. Less-frequently mentioned categories of barriers include government systems, male involvement, access, attitudes, policy, data and IEC.

Respondents also provided information on factors that contribute to the success of dual protection and integration projects (see Annex 6). Commitment, collaboration and stakeholder involvement are especially important, and include issues such as multilateral support, emphasis on coalitions and partnerships, and the perceived need for prevention (155 of 409 enabling factors listed). Service provision is also important (46) and includes guidelines and training for staff, staff with appropriate technical and counseling skills, and the use of private sector / NGO networks of service delivery. Mentioned somewhat less frequently were issues related to supervision and peer education (22), IEC/BCC activities, including use of existing channels for scaling-up (21), access to condoms and contraceptives (19), and the extent and awareness of the epidemic (5).

IV. DISCUSSION AND RECOMMENDATIONS

This survey produced a number of important findings that can be used by policy makers and program managers interested in integration as a strategy for improving overall reproductive health and reducing the spread of HIV/AIDS. In some cases, however, the information raises more questions than it answers.

One important finding is that the amount of PHN funds allocated to integration activities has increased substantially over the course of just a few years, as part of an overall increase in USAID and PHN funds devoted to HIV/AIDS prevention.[3,4] This commitment by USAID may facilitate efforts to address the threat of HIV/AIDS as well as to improve overall reproductive health. However, there is great need for further assessment of integrated programs to explore their success and efficacy.

It is important to note that in the first years covered by this survey, over half of the funds for integration work were channeled through bilateral programs. This has declined in recent years and may be a function of bilateral projects normally focusing on either HIV/AIDS or family planning, but not both. Missions that identify integration as a strategy to explore may find that core or field funded projects are able to provide more technical assistance than bilateral projects that focus only on one issue. Funding trends of this sort merit continued attention.

It is also important to recognize the fact that the funding reported in this survey reflects only a portion of all international funding for integration. Only responding agencies are included and these represent only some of those that receive USAID funding. Although some information about funding from other donors is included, this does not show the entire picture of international funding. Such information is important for collaborative mapping of needs and programs to address those needs.

Of all the dual protection and integration projects, most are working in Africa and somewhat fewer are working in Latin America and the Caribbean. The ANE and E&E regions, however, make up a much smaller portion of all of the projects and activities. As two regions where HIV/AIDS is beginning to become a significant problem, it will be important to establish more programs to work on prevention in order to intervene effectively before HIV/AIDS reaches epidemic proportions here.

This survey also brings to light the fact that only 68% of the dual protection projects distribute condoms, even though all promote condoms for infection and pregnancy prevention. Although there are a multitude of barriers to contraceptive provision and condom distribution, the survey shows that there is not any one type of activity or population group associated with non-distribution of condoms. It is important to explore the reasons why projects that are delivering services such as family planning counseling, social marketing, VCT, PAC, and maternal health services are not distributing condoms.

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3 "USAID Budget Dedicated To HIV/AIDS Annually", website accessed September 26, 2002. http://www.usaid.gov/pop_health/aids/Funding/FactSheets/hiv_budget.html.

4 "Funding Trends for Population Health and Nutrition," website accessed September 26, 2002. http://www.usaid.gov/pop_health/pop/funding/trends.html.

Survey Constraints

The purpose of this survey was to create an inventory of activities working to integrate family planning/reproductive health and HIV/AIDS services. The survey gathered mostly quantitative data and did not seek to assess the efficacy of the actual activities. This survey was not an evaluation of the work of any agency.

In addition, the survey design was not meant to be scientific. The information presented here is self-reported and should be taken at face value. There is no control on data quality. The only information that is presented is what the survey respondents provided in the forms. Although many of the organizations that are known to work in the areas of family planning/reproductive health and HIV/AIDS responded to the survey, significant others did not. Organizations were asked to provide a coordinated, comprehensive response of all projects with integration activities, however, there may be projects that were overlooked or not captured in this inventory.

The format of the funding questions is one major constraint in the survey design. Because funding was grouped by organization and not by activity, it is impossible to detect how much funding is used for each activity. A much more in-depth exploration of cost will have to be undertaken to determine cost-effectiveness and efficiency of integrated activities.

In addition, questions in the dual protection and integration questionnaires were not asked in the same way. In general, questions in the integration portion of the survey requested more specific information. For example, the integration questionnaire provided a list of 38 different types of activities from which to choose, while the dual protection questionnaire listed only nine major categories. Categories for types of clients served were also more specific in the integration questionnaire.

Another possible constraint of the survey was its format as an Access database. The Working Group and the AA/CC Team decided to use Access because we believed that most agencies had the program and would be able to use it. In addition, because Access is part of Microsoft Office, which almost all agencies have, the data would be more accessible for further analysis by other agencies than if another program was used. As it happened, however, some agencies found Access difficult to use or did not even try to use it. In one case, a responding agency had to install Access on a staff person's computer solely for the purpose of filling out the questionnaire. In other cases, there were issues of duplication of data (although this was rectified in the process of cleaning the data). It had been assumed that because all of the agencies to whom the survey was sent were in developed countries, they would have the Access program. But in some cases, large organizations sent the survey to their field offices in other countries, and those offices did not have Access or could not use it. They either typed the information on the paper form, or answered the questions in a Word document.

Perhaps the most significant constraint of using Access was the added difficulty of analyzing the data and the inability to conduct more sophisticated types of analysis. Because of the format of the survey, it was not possible to export the data into an analysis program such as SPSS. Therefore, all analysis could only be conducted in Access.

Recommendations

Upon completion of this inventory, Advance Africa and the CATALYST Consortium have several recommendations:

As data on integrated family planning and HIV/AIDS activities is rare, it will be important to gather more in-depth information from those agencies that are implementing the projects in this area. In order to be strategic, perhaps those organizations that have the most activities and receive the most USAID funding should be targeted for assessment of integration projects. Such assessments should evaluate the success, replicability, sustainability, and cost-effectiveness of integrated activities and document the findings. It will also be important to explore smaller activities that may be very successful as time and funding allows. These findings will be critical to inform future integrated approaches.

Although the majority of current projects are working in Africa, it is vital that donors expand funding for regions where HIV/AIDS is just starting to become a problem, such as South and Southeast Asia and the former Soviet Union. In these areas, it is important to maintain gains and scale up both family planning and HIV/AIDS prevention programs. Although we do not have evidence of the effectiveness and efficiency of integrated programming, this approach appears to provide a mechanism to achieve both of these goals.

Finally, because there is little information in this survey about the integration activities undertaken by other donors, it would be useful for USAID to coordinate with other major donors to share information on integration and dual protection projects, lessons learned and opportunities for collaboration in the field.

ANNEX 1: QUESTIONNAIRES

ANNEX 2: TIMELINE

Activity	By Whom	Estimated Date of Completion
Review and provide comment on the FP/HIV/AIDS Integration Matrices	AA/CC Team	June 4, 2001
Create Access Database for Matrices	Nina, Yvette	July 2, 2001
Analyze pilot responses to Matrices from AIDSMARK and CCP	AA/CC Team	July 27, 2001
Present pilot findings to USAID Integration WG	AA/CC Team	July 30, 2001
Send database to CAs	Duff Gillespie	September 19, 2001
Create survey forms as PDF files for those without Access	YC	September 21, 2001
Survey due back to Nina	CAs	October 12, 2001
Have Senior Evaluation Advisors review data analysis plan	SEAs	October 12, 2001
Follow-up telephone calls to make sure we get all surveys, and for any clarifications needed	USAID working group	October 12, 2001
Enter and clean data from survey responses	Data entry – Nina Data cleaning – Yvette	November 13, 2001
Meeting of AA/CC Team to review data analysis plan	AA/CC Team	November 9, 2001
Surveys received (majority)	CAs	December 1, 2001
Conduct preliminary analysis of data based on questions developed by the WG and AA/CC Team Members, present initial data analysis to AA/CC Team	Nina and Yvette	November-December, 2002
Present (preliminary) findings to USAID Integration WG	AA/CC Team	January 10, 2002
Conduct further analysis	AA/CC Team	Spring 2002
Decision not to wait for further data	Nomi Fuchs	July 31, 2002
Finalize report		Summer 2002

ANNEX 3: ADVANCE AFRICA/CATALYST CONSORTIUM TEAM

Leads: Nina Pruyn, Advance Africa
Yvette Cuca, CATALYST Consortium

Advance Africa	Kwame Asiedu
	Belkis Giorgis
	Miho Sato
	Lalla Toure
CATALYST Consortium	Walid Abubakar
	Reynaldo Pareja
	Zynia Rionda

ANNEX 4: USAID INTERAGENCY FP/HIV INTEGRATION WORKING GROUP

Coordinator Nomi Fuchs

Nomi, Please help us with these names…

FPS Michele Moloney-Kitts

Research Jeff Spieler

HIV

ANNEX 5: LIST OF INDICATORS

1. KAP

- Change reproductive, maternal and child health behavior to establish district capacity to sustain services.
- Changes in knowledge, attitudes, and practices regarding HIV/AIDS transmission and prevention (2)
- Clients in intervention zones report increase in condom use (2)
- Clients in intervention zones report knowledge of correct use of condoms and access to condoms (2)
- Condom use (10)
- Consumer awareness of HIV prevention and family planning promoted via the media.
- Consumer awareness of HIV prevention promoted via SM radio spots.
- Cultural context of HIV/AIDS and surrounding belief systems
- Current antenatal and birthing practices and beliefs
- Decrease in myths and attitudes that prevent the adoption of safer sex behavior by young people
- Dual protection methods used
- Duration of dual protection use
- Exclusive breastfeeding rate among women of known HIV status;
- Exclusive breastfeeding rate among women of unknown HIV status;
- First postnatal visit
- General increase in consistent use of condoms, particularly among high risk groups.
- Health-care seeking behavior among high-risk groups
- Improve knowledge, attitude and practices amongst youth
- Improved attitude towards condoms for dual protection
- Improved couple communication
- Improved individual and community norms and behaviors conducive to better health
- Improved infant feeding
- Improved infant nutrition
- Improved knowledge of health practices and services
- Improved Knowledge, Attitude, and Practice (KAP) among target audience, parents, and community members related to STD/HIV prevention.
- Improved Knowledge, Attitude, and Practice (KAP) among target audience, parents, and community members related to STD/HIV prevention.
- Improved partner communication skills
- Improved skills of youth clients in condom negotiation techniques (2)
- Improvement in knowledge, attitude, and practices, including accurate personal risk assessment and reported condom use.
- Improvement in knowledge, attitude, and practices, including accurate personal risk assessment and reported condom use.
- Improvements in knowledge, attitudes, and practices regarding condom and other contraceptive use, linked with practices that help prevent HIV/AIDS/STI transmission.
- Improvements in knowledge, attitudes, and practices regarding condom use and HIV/AIDS prevention (e.g., increase in reports of condom use).
- Increase awareness of importance of condoms and greater condom use, especially among males
- Increase awareness of importance of condoms and greater condom use, especially among males
- Increase in 15-24 year-olds' understanding of HIV/AIDS and reported frequent use of condoms.
- Increase in awareness of, knowledge about, and attitudes toward safer sexual practices.
- Increase in awareness of, knowledge about, and attitudes toward safer sexual practices.
- Increase in birth spacing.
- Increase in birth spacing.
- Increase in clinic attendance
- Increase in consistent use of condoms, particularly among high risk groups.
- Increase in consistent use of condoms. (2)
- Increase in demand for and awareness of VCT.
- Increase in demand for condoms

- Increase in discussion with spouse, partner, etc.
- Increase in intention to use a family planning method
- Increase in intention to use FP method
- Increase in knowledge about and reported use of condoms to prevent HIV/AIDS/STIs and unintended pregnancy.
- Increase in knowledge about and reported use of condoms to prevent HIV/AIDS/STIs and unintended pregnancy.
- Increase in knowledge about condoms
- Increase in knowledge regarding STIs/HIV/AIDS, family planning, and treatment of dehydrated children.
- Increase in knowledge regarding STIs/HIV/AIDS.
- Increase in Percent of MRA using condoms at last sex act (2)
- Increase in percent of target group respondents who agree that condoms are appropriate and necessary for use within "sweetheart" and casual relationships, and in sex between clients and indirect CSWs.
- Increase in percent of target population able to accurately assess their personal risk of HIV infection and who report discussing prevention with partners, using condoms, and willingness to seek VCT. (2)
- Increase in reported condom usage.
- Increase in reported condom use among target populations (2)
- Increase in reported knowledge about and use of condoms for prevention of HIV/AIDS, especially in high-risk activities (e.g., sex with non-regular partner). (2)
- Increase in reported knowledge about, demand for, and use of condoms and VCT.
- Increase in reported use of condoms and knowledge about HIV/AIDS transmission among target groups. (2)
- Increase in reported use of condoms by target population.
- Increase in reported use of condoms by target population.
- Increase in reported use of condoms nationwide.
- Increase in reported use of condoms.
- Increase in reports of access to, knowledge about, and use of condoms and other contraceptives as part of integrated behavior change for family planning and HIV/AIDS/STI prevention
- Increase in reports of access to, knowledge about, and use of condoms
- Increase in reports of condom use.
- Increase in reports of condom use.
- Increase in risk perception and corresponding behavior change among those at high risk for contracting HIV/AIDS/STIs and those likely to experience unintended pregnancies.
- Increase in risk perception and corresponding behavior change among those at high risk for contracting HIV/AIDS/STIs, including increased report of condom use and positive change in knowledge, attitudes, and behavior
- Increase in surveyed and reported awareness and knowledge of HIV/AIDS and prevention.
- Increase in surveyed and reported awareness and knowledge of HIV/AIDS and prevention.
- Increase in the baseline level of respondents who state that they used condoms "all the time" in commercial or casual sex during the past two months. (2)
- Increase in the percent of high-risk populations knowledgeable regarding correct use of condoms.
- Increase in the percent of high-risk populations knowledgeable regarding correct use of condoms.
- increase in the percent of target populations who know where they can get an affordable condom and/or be tested for HIV (2)
- Increase in the percent of the target populations reporting use of condom with last casual partner.
- Increase in the percent of the target populations reporting use of condom with last casual partner.
- Increase in the voluntary use of modern contraceptives.
- Increase in understanding of HIV/AIDS
- Increase in use of sustainable, integrated primary health care services. (2)
- Increase in voluntary use of modern contraceptives for family planning. (6)
- Increase in young men understanding issues of gender equality, safer sexual practices.
- Increase knowledge and positive attitudes about condoms for dual protection
- Increase practice of using FP method
- Increased awareness, knowledge and positive attitudes about RH issues

- Increased client awareness of dual protection for HIV/STI and pregnancy prevention
- Increased client condom use for dual protection
- Increased demand
- Increased demand for MCH/FP/HIV AIDS services
- Increased demand for PHN interventions among caregiving mothers, youth, men
- Increased demand for PHN interventions among caregiving mothers, youth, men
- Increased knowledge about STIs/HIV
- Increased knowledge and positive attitudes towards DP and HIV/AIDS prevention
- Increased knowledge of modern contraceptives
- Increased knowledge on transmission of HIV/AIDS
- Increased knowledge on when and how pregnancy occurs
- Increased knowledge on where condoms can be obtained
- Increased number of requests for condoms by clients
- Increased reported use of, belief in efficacy of, availability of, and knowledge about condoms to prevent HIV and unintended pregnancy. (2)
- Increased self-efficacy to protect oneself against HIV/AIDS and unwanted pregnancies
- Increased support of clients for partner communications including condom and safer sex negotiations
- Increased time between pregnancies permitting longer breast feeding.
- Increased use of youth-friendly services by youth
- Increases in number of clients using RH/FP methods
- Intent to use condoms for protection
- Knowledge and attitude changes, etc
- Number clients using dual protection
- Number individuals (male, female) citing at least two effective means of portection from STI infection
- Number individuals (male, female) citing at least two effective means of portection from STI infection
- Number of calls to hotlines
- Number of clients using condom
- Number of clients using condon
- Number of genuine phone calls to the helpline
- Number of genuine phone calls to the helpline
- Number of new and continuing family planning clients by age and parity (2)
- Number of new clients attending clinics
- Number of visits to reproductive health clinics
- Partner notification
- Percent of adults of reproductive age who approve of family planning (2)
- Percent of adults of reproductive age who know spontaneously 3+ modern methods (2)
- Percent of adults practicing low risk behavior for STD/HIV (Safe Sex Composite Indicator) (2)
- Percent of family planning clients using condoms and percent using both condoms and another contraceptive method (2)
- Percent of men using condoms with their last non-regular partners
- Percent of men using condoms with their last non-regular partners;
- Percent of men who used condom at last sexual encounter (2)
- Percent of population using modern contraception
- Percent of target audience that know that condoms and abstinence protect against both pregnancy and STI/HIV (2)
- Percent of women of reproductive age using family planning (2)
- Percent of women reporting condom use or other protective measures (2)
- Percent of women reporting consistent (always) condom use by partner. (2)
- Percent of women reporting they can speak with partners about FP, STDs and HIV (2)
- Percent of women using condoms with their last non-regular partners (2)
- Percent of women who are aware that HIV can be transmitted via pregnancy and childbirth
- Percent of women with a post-natal visit in a health facility no more than one week (0-7 days) after birth
- Percent of women with at least one ANC visits
- Percent of WRA using condoms
- Percent of WRA using condoms

- Percentage increase in risk-reducing behaviors among target audience
- Percentage of multiple partners using condoms (2)
- Percentage of people with correct knowledge on HIV/AIDS prevention
- Percentage of people with correct knowledge on HIV/AIDS prevention
- Persons' condom use (6)
- Persons using condoms (2)
- Positive attitudes towards condom use
- Pre/post test evaluation of attitudes and knowledge
- Proportion of couples desiring a child who access VCT services
- Proportion of key client groups practicing contraception
- Proportion of men and women who use condoms for dual protection
- Reduced HIV risk behaviors
- Reduced number of unprotected sex acts
- Reduction in reported number of non-regular partners. (2)
- Reported condom usage and in voluntary use of modern contraceptives for family planning.
- Reported increase in condom use among youth and CSWs.
- Reported use behaviors in men and women.
- Reported use of condoms at last sex
- Reports by target population that their reason for not using condoms is that they "are not effective."
- Self reported condom use
- Self-reported behavior changes among clients regarding safer sex. (2)
- Target population's belief that a healthy-looking person can be infected with HIV.
- Target population's belief that they would be at risk for HIV/AIDS if they did not use a condom.
- Target population's reports of discussing condom use with their partner.
- Training participant pre/post-test on knowledge and attitudes (11)
- Use of Condoms (2)
- Use of contraceptive services (2)
- Use of STD/HIV/AIDS prevention, diagnosis and treatment services by youth (2)
- Users reported
- Visits for STI care
- Visits for STI care (MOH Indicator)
- Decrease in myths and attitudes that prevent the adoption of safer sex behavior by young people

2. CAPACITY AND SUSTAINABILITY

- Capacity of existing health care systems.
- Cost of providing services
- Cost of services
- Cost per client
- Development and piloting of CSM program.
- Development and piloting of CSM program.
- Development and piloting of PPT program.
- Development and piloting of prepackaged therapies program.
- Development and piloting of VCT program.
- Development and piloting of VCT program.
- Development of facitility-level integration plan
- Development of IEC, VCT for women, breast milk substitution
- Distribution plan created and implemented
- Efficiency and effectiveness of PHC service delivery
- Enhancement of program human resources.
- Enhancement of program human resources.
- Feasibility of on-site testing for syphilis
- Growth in capacity of health care system in Haiti with respect to VCT and MTCT prevention.
- Growth in the capacity of Population Services International, Options Santé Familiale (OSFAM), the Guinean affiliate of PSI, and the number and performance of health care workers employed and/or trained.

- Growth in the capacity of Population Services International, Options Santé Familiale (OSFAM), the Guinean affiliate of PSI, and the number and performance of health care workers employed and/or trained.
- Improved ability of communities to identify and solve health problems (2)
- Improved community support: "from participation to ownership"
- Improved coordination between the public and private sectors
- Improved skills of Peer educators in condom negotiation techniques (2)
- Increase in capacity of indigenous NGOs and private sector to carry out effective HIV/AIDS prevention activities.
- Increase in capacity of PSI programs (e.g., number and performance of health care providers trained).
- Increase in capacity of PSI programs (e.g., number and performance of health care providers trained).
- Increase in local capacity to manage a national social marketing program.
- Increase in local capacity to manage a national social marketing program.
- Increase in partner organization's capacity (e.g., increase in skills sharing and cooperation among organization participants).
- Increase in self-sustaining institutional sales networks as indicated by increase in institutional/employee-based sales and number of on-going, repeat sales and peer education programs established. (2)
- Increase in use and capacity of sustainable, integrated primary health care services. (2)
- Increase reach to people in high transmission areas.
- Increased capacity of local institutions to implement PHN interventions
- Increased capacity of local institutions to implement PHN interventions
- Increased funding from public and private sector for youth initiatives.
- Increased number of providers and CHWs capable of providing good counselling
- Increased number of providers and CHWs capable of providing good counselling
- Increased project cost efficiency, as indicated by decrease in cost per condom sold, level of revenues as a percent of project costs, and level of co-financing (2)
- Linkages and Improved coordination
- Maintenance of strategies to assure financial stability, including effective product cross-stabilization (2)
- Number of clinic staff oriented to integration program planning issues
- Number of community based distributors trained to counsel and promote dual protection (2)
- Number of community health workers trained on family planning topics (3)
- Number of community health workers trained on STD/STI/HIV topics (3)
- Number of community RH workers with no stockouts (2)
- Number of drama troupes trained in RH issues.
- Number of educators and health care providers trained (2)
- Number of field workers trained in infant feeding counseling
- Number of health care providers trained.
- Number of health care workers trained (e.g., VCT sites monitored via exit surveys and mystery client surveys).
- Number of health care workers trained in family planning and HIV prevention.
- Number of health workers trained in FP provision and STI syndromic management
- Number of health workers trained in FP provision and STI syndromic management
- Number of health workers trained in FP/STI/HIV behavior change communication
- Number of health workers trained in FP/STI/HIV behavior change communication
- Number of health workers with skills in integrated services
- Number of helpline counselors trained in DP/RH and HIV/AIDS counseling
- Number of peer educators trained (3)
- Number of providers and community health workers trained in counselling skills (2)
- Number of providers and community leaders trained in HIV/AIDS prevention and control
- Number of providers trained (11)
- Number of providers trained in HIV/AIDS prevention and control,
- Number of providers trained in youth-friendly services

- Number of providers trained.
- Number of PVO supported facilities which achieve 100 Percent recurrent cost recovery (2)
- Number of REFLECT facilitators trained and active (youth and adult)
- Number of REFLECT facilitators trained and active (youth and adult)
- Number of staff trained
- Number of trainers trained (12)
- Number of training sessions on integrated services
- Number of youth peer educators employed and trained.
- Number providers trained
- Organizational capacity improved to run large centralized toll free hotline
- Peer educators trained
- Peer educators trained
- Percent of trained field workers who can demonstrate correct counseling
- Percent of trained health providers with an acceptable level of competency in maternal and neonatal health skills at the of the project
- Providers trained (3)
- Success in lowering dependency on donor funds by marketing higher-priced condom brand in order to cross stabilize lower cost brand, other contraceptives, and other family health products
- Success in lowering dependency on donor funds by marketing higher-priced condom brand in order to cross stabilize lower cost brand.
- Success in procurement of essential commodities.
- Successful creation and maintenance of partnerships.
- Sustainable condom social marketing.
- Teachers/other supportive adults trained
- Trainers trained
- Trainers trained
- Training courses and sessions (12)
- Training of providers
- Youth groups trained in interactive theatre to address RH/DP and gender issues

3. ACCESS TO AND AVAILABILITY OF CONDOMS

- Access to and availability of condoms and increase in contraceptive prevalence rate (CPR).
- Access to integrated package of PHC services increased
- Commodities distributed
- Condom accessibility
- Condom availability studies and tracking of overall condom market.
- Condom availability studies and tracking of overall condom market.
- Condom distribution
- Condom distribution
- Condoms available at intervention sites
- Condoms sold/distributed
- Condoms sold/distributed
- Expansion in coverage in traditional (pharmacy) and non-traditional (hotels, bars, kiosks, etc.) sales outlets for condoms
- Expansion in coverage in traditional (pharmacy) and non-traditional (hotels, bars, kiosks, etc.) sales outlets for condoms.
- Increase availability of condoms
- Increase in access and availability of condoms in traditional and non-traditional outlets
- Increase in access and availability of condoms, other contraceptives, and family health products
- Increase in access and availability of condoms, particularly via expansion of number of outlets. (2)
- Increase in access and availability of condoms.
- Increase in access to and availability of condoms (including affordability).
- Increase in access to and availability of condoms.
- Increase in access to condoms (number of bars, hotels, and retailers carrying condoms
- Increase in accessibility and availability of condoms
- Increase in accessibility and availability of condoms (4)

- Increase in accessibility and availability of condoms and other contraceptives
- Increase in affordability and accessibility of condoms in traditional and non-traditional outlets. (2)
- Increase in annual condom sales. (2)
- Increase in availability of and access to condoms and increase in the contraceptive prevalence rate.
- Increase in availability of and access to condoms, contraceptives, and other family health products.
- Increase in availability of and access to condoms, particularly in non-traditional outlets such as bars, kiosks, and guesthouses
- Increase in availability of and access to condoms.
- Increase in condom sales (3)
- Increase in distribution outlets, both traditional (e.g., pharmacies) and non-traditional (e.g., kiosks, supermarkets, bars).
- Increase in Number of condoms distributed via SM outlets
- Increase in number of outlets providing condoms and other HIV/AIDS products and services available where and when the target populations need them (2)
- Increase in number of sales outlets in rural areas (2)
- Increase in reported access to condoms
- Increase in retail availability of condoms in targeted high HIV prevalence districts.
- Increase in retail availability of condoms in targeted high HIV prevalence districts.
- Increase in stable supply and availability of condoms, including non-traditional outlets (e.g., beauty salons--visited weekly by many urban Zambian women--for the female condom).
- Increase in the availability, sales, and reported use of condoms, other contraceptives, and family health products.
- Increase in the Number of condoms distributed in each quarter (both male and female)
- Increase in the number of outlets distributing condoms
- Increase in the number of outlets distributing condoms, contraceptives, and other family health products
- Increase in the percent of outlets (traditional and non-traditional) in high-risk urban areas carrying affordable condoms.
- Increase in the percent of outlets (traditional and non-traditional) in high-risk urban areas carrying affordable condoms.
- Increase in widespread access to affordable condoms nationwide (as indicated by sales and surveys).
- Increase in widespread access to affordable condoms nationwide (as indicated by sales and surveys).
- Increase of condom accessibility (especially in non-traditional venues such as "barracas" bar/market stalls, nightclub/hotels, or traditional healers) (2)
- Increased access
- Increased number of condoms distributed to new and ongoing FP clients
- Level of expansion of private sector wholesale and distribution outlets for condoms, other contraceptives, and family health products, including maintenance of stable resupply patterns and increase in non-traditional outlets (2)
- Number condoms distributed
- Number of BodyGuard condoms sold
- Number of condoms distributed
- Number of condoms distributed
- Number of condoms distributed (2)
- Number of condoms sold at sentinel pharmacy sites
- Number of NGOs selling BodyGuard condoms (2)
- Reduced stockouts
- Reduced stock-outs
- Reports from youth on accessibility and affordability of condoms).
- Sales of "Favorite" brand condom
- Sales of "Number One" condoms. (2)
- Sales of condoms and other contraceptives. (3)
- Sales of condoms to military for distribution.
- Sales of condoms, contraceptives, and other family health products.

- Sales of condoms, especially among high-risk groups. (2)
- Sales of condoms, especially to poor and high-risk clients. (2)
- Sales of condoms, other contraceptives, and family health products (including oral rehydration salts and insecticide treated mosquito nets).
- Sales of condoms, other contraceptives, and family health products. (3)
- Sales of condoms, other contraceptives, and lubricant, along with increase in distribution outlets and provider networks.
- Sales of condoms. (28)
- Sales of CSM program condom brand.
- Sales of male and female condoms.

4. FP USER DATA

- Contraceptive prevalence and/ or CYPs generated (8)
- Contraceptive prevalence rate (12)
- Contraceptives distributed
- Couple Years of Protection (40)
- Couple-Years of Protection provided by method (3)
- Couple-Years of Protection via condoms (15)
- Couple-Years of Protection via condoms and other contraceptives (13)
- CPR and CYP trends (4)
- Decrease in Number of unplanned pregnancies
- Decrease in the Number of unplanned pregnancies in the catchment areas
- Decreasing the number of abortions
- Fertility trend
- Fertility trend
- Increase in CPR in FHA demonstration countries;
- Increase in distribution and use of other contraceptives (including an increase in use of "OK" oral contraceptives among non-contracepting women and those users dissatisfied with other products and methods).
- Increased contraceptive prevalance rate among youth.
- Increased contraceptive prevalence rate among youth.
- New FP acceptors
- Number of FP acceptors by method (3)
- Reduction in incidence of unintended pregnancy
- Reduction in incidence rates of unintended pregnancies (14)

5. IEC MATERIALS AND ACTIVITIES

- Attendance at activities
- Community dialog around youth issues, repro health
- Community meeting with male and adolescent boys on HIV/AIDS
- Community meeting with male and adolescent boys on HIV/AIDS
- Coverage of and/or attendance at BCC programs, media campaigns, and promotional events. (2)
- Curriculum developed
- Estimated total target population in intervention zone receiving STI messages
- Estimated total target population in intervention zone receiving STI messages
- IEC/BCC materials and aids produced and distributed
- IEC/BCC materials and aids produced and distributed (18)
- IEC materials developed
- IEC materials produced
- IEC/BCC materials produced
- IEC/BCC sessions by type (home, group and public) (18)
- Increase in social marketing of condoms.
- Increase in social marketing of condoms.
- Increased number of condom demonstrations
- Level of community participation at community events (2)
- Materials development

- Materials produced
- Measure of effectiveness of media and BCC campaigns (2)
- Measurements of BCC campaigns aimed at "sweetheart" relationships.
- Measurements of BCC campaigns, and of number of and attendance at promotional events.
- Measurements of impact of community-wide educational campaigns (in media and via peer education).
- Measures of effectiveness of media, education, and other BCC campaigns.
- Measures of effectiveness of media, education, and other BCC campaigns.
- Measures of jointly designed and disseminated public relations materials.
- Media deliverables and public promotional events (2)
- Meet targeted number of and attendance figures for promotional events.
- Memorability of media campaigns (e.g., increase in the percent of target populations able to accurately recall mass media safer sex messages) (2)
- Memorability studies of media initiatives (e.g., TV, radio, internet) (2)
- Number and coverage of BCC deliverables (promotional events, media campaigns, etc.).
- Number of attending community mobilization events in the 12 districts
- Number of BCC deliverables (Junction Town Drama troupes, radio dramas, and media campaigns).
- Number of centerpiece materials broadcast (videos, radio programs).
- Number of chapters which incorporated RH components
- Number of client materials, provider materials, and television spots produced
- Number of clients/households educated about the prevention of HIV/AIDS
- Number of community activities conducted
- Number of copies distributed
- Number of distance ed radio episodes produced and broadcast.
- Number of IEC materials distributed (2)
- Number of IEC materials produced and distributed
- Number of IEC sessions related to HIV/AIDS (2)
- Number of materials distributed in the 12 DISH districts
- Number of materials produced and distributed (e.g. CHEST Kit, Women's Group Kits)
- Number of men reached
- Number of neighborhood health committees established (2)
- Number of participants
- Number of people informed on HIV/AIDS
- Number of people informed on HIV/AIDS
- Number of people informed through family planning talks (groups) (3)
- Number of people informed through STD/STI/HIV talks (groups) (3)
- Number of people that attend campaign events
- Number of respondents exposed to mass media products
- Number of spots and radio programs broadcast (2)
- Number of video packages of interactive theatre for RH and gender issues
- Number of youth involved in community action committees
- Number women participating in IEC sessions that have integrated RH messages (2)
- Numbers of and attention paid to promotional and media campaigns.
- Percent of target population that has seen or heard of message about program brand condoms or generic condom message which promotes consistent condom use. (2)
- Persons educated with accurate messages (2)
- Post-testing of BCC and mass media messages (5)
- Press coverage. (2)
- Promotional events (2)
- Provide workshops to NGOs, public sector, and private sector (2)
- Quality and clarity of training materials (9)
- Range and recall of advertising, media campaigns, and educational events (2)
- Recall of messages presented through media and/or interpersonal communication. (2)
- Recall of safer sex and family planning messages promoted through regional BCC and SM campaigns (4)

- Up to 20 youth focused NGOs and NGO networks will have conducted or be engaged in IEC and mobilization activities for youth reproductive health. (2)

6. QUALITY CLINICAL SERVICES

- Accurate VCT as gauged by mystery client surveys. (2)
- Clients counseled
- Clients served
- Compliance in application of clinical guidelines
- Correct classification of clients
- Correct use of clinical guidelines
- Couple counseling
- Development and dissemination of quality standards
- Efficacy of current VCT services
- Establishment of VCT standards and training for health care providers, especially antenatal care providers.
- Improve care of PWAs
- Improve reproductive health services
- Improved quality
- Increase in correct STI diagnosis and treatment among target populations (2)
- Increase in Number of 15 - 24 yr-olds getting HIV counseling and information at SFPS-supported hotlines
- Increase in Number of 15-24 year olds getting HIV counseling and information at FHA-supported hotlines
- Increase in Number of 15-24 year olds getting HIV counseling and information at FHA-supported hotlines
- Increase in the Number of clients that are informed about dual protection.
- Increased proportion of clients who receive information and counseling about dual protection,
- Increased quality for MCH/FP/HIV AIDS services
- Make services more readily available to communities and under-served populations. Make services more responsive to client demands and rights.
- Measurements of service delivery (including VCT, antenatal care, ARV prophylaxis, and counseling)
- Number clients counseled
- Number of clinic demonstrations conducted
- Number of clinics that consistently meet quality improvement standards.
- Number of customer received services from satellite clinic in red-lighted areas (2)
- Number of health services providing integrated services
- Number of monitoring visits to check quality criteria compliance
- Number of people counseled on family planning (individual/couple/home visits) (3)
- Number of people counseled on STD/STI/HIV (individual/couple/home visits) (3)
- Number of people treated for STDs or STIs (3)
- Number of person oriented on HIV/AIDS (2)
- Number of reproductive health clients that received counseling in dual protection (2)
- Percent of health facilities in MNH program area maintaining infection prevention practices
- Percent of health providers who counsel women about HIV/AIDS during ANC visits
- Percent of women correctly treated for RTI
- Percent services meeting national and international norms for CS and RH service quality (2)
- Performance of educators and health care providers trained (2)
- Performance of health care providers trained.
- Performance of health care workers trained (e.g., VCT sites monitored via exit surveys and mystery client surveys).
- Performance of health care workers trained in family planning and HIV prevention.
- Performance of providers trained.
- Performance of youth peer educators employed and trained.
- Proportion of providers who correctly perform tasks.
- Proportion of women tested and treated for syphilis
- Providers counsel study participants on condom use and provide condoms

- Quality of counseling
- Quality of trainers (11)
- Standards developed
- VCT provided (2)
- Voluntary counseling and testing (VCT) of HIV uptake among antenatal women and mothers of infants 0-<12 months old
- Whether clients acquired new and accurate information regarding STI/HIV/AIDS prevention (2)

OTHER

- Active community counselors
- Activity records completed
- Assessments of potential for other SM products.
- Average antenatal attendances
- Clinical signs and symptoms of STIs
- Country program integration plans developed, etc.
- Coverage of districts
- Decrease in STI infections in catchment areas
- Decrease in the Number of STI cases seen at the catchment clinics
- Evaluation survey for product users
- Expansion of VCT
- Formal policy statement drafted and reviewed by policy makers
- Formative and baseline research and surveys of target groups.
- Formative and baseline research and surveys of target groups.
- HIV incidence,
- HIV serosurveys
- HIV transmission from mother to child prevented
- How well the café's programs operated.
- How well the café's programs operated.
- Implementation of campaigns aimed at improving management and prevention of STIs/HIV/AIDS. (2)
- Improved access to PHC services, including HIV/AIDS, sexually transmitted infections and tuberculosis
- Improved access to services through better referral systems for counsellors using helpline
- Improvement in maternal and child health.
- Improvement of legal environment barring the advertising or introduction of some methods of contraception.
- Incidence of pregnancy in women,
- Increase availability and utilization of reporductive, maternal and child health services in Uganda
- Increase community support and buy-in for services.
- Increase in demand for, access to, affordability of, and quality of service provided by "New Start" VCT centers, including referrals from FP clinics.
- Increase in demand for, access to, affordability of, and quality of service provided by "New Start" VCT centers (measures include number of clients served and percent who return to retrieve results).
- Increase in Number of health and development organizations using FHA developed tools and approaches
- Increase in Percent of MRA using condoms at last sex act in FHA demonstrations countries
- Increase in sales of other contraceptives.
- Increase in support from port management and involvement of key stakeholders, such as the All India Motor Transport Congress.
- Increase in support from port management and involvement of key stakeholders, such as the All India
- Increase in the Contraceptive Prevalence Rate and expansion of availability of contraceptives and oral rehydration salts in under served rural areas accomplished via a program that integrates a STI/HIV prevention message.
- Increase number of health and development organizations using FHA developed tools and approaches.
- Increase number of health and development organizations using FHA developed tools and approaches.

- Increase the efficacy of prevention and care.
- Increased access to MCH/FP/HIV AIDS services
- Increased access to quality RH, STI/HIV/AIDS and CS Services and Products
- Increased availability of quality RH, STI/HIV/AIDS and CS Services and Products
- Increased dissemination & adoption of best practices to improve supply and demand of RH, STI/HIV/AIDS and CS Services and Products in W. Africa
- Increased prevention of HIV
- Increased support for ARH among policymakers and community leaders
- Influence of media campaigns and promotional events (2).
- Integration of family health products and services delivery with HIV/AIDS prevention efforts.
- Levels of condom use.
- Male involvement
- Meeting targeted identification of collaborative opportunities.
- Meeting targeted level of provision of ongoing assistance to both US and Russian partners.
- National policies and plans promote and sustain access to high-quality FP/RH/AIDS services in Nigeria
- Number of clients referred for STI treatment to the local clinics
- Number of completed referrals for FP, VCT, STD treatment (2)
- Number of districts using SCOPE health management tool (2)
- Number of HIV/STI activities undertaken
- Number of improved policies, plans, guidelines for FP/RH/HIV/AIDS adopted/ approved
- Number of partners traced and seeking treatment for STIs.
- Number of people referred for treatment for STDs or STIs (3)
- Number of potential HIV/STI activities identified to integrate
- Number of referrals made for maternal cases
- Number of sites identified for replication
- Number of staff participating in planning process
- Number of STI cases diagnosed and treated
- Number of STI cases diagnosed and treated
- Number of women's networks which initiate or strengthen RH and STI/HIV program/services
- Number of youth centres providing RH information and services
- Number persons in intervention zone within 15km of facility offering CS services (4)
- Number PVO supported facilities (2)
- Numbers refered
- Numbers seen for VCT, TB, FP, STD and HIV
- Participant satisfaction with the process, etc
- Percent of adults and youth referred for HIV/AIDS/STI services, VCT, or FP
- Percent of births assisted by a skilled provider in a health facility
- Percent of parishes with at least 2 active community RH workers (2)
- Percent of population with access to CS services, and access to FP services (2)
- Prevalence and geographic distribution of HIV/AIDS
- Prevalence of RTI, based upon laboratory and clinical guidelines
- Prevalence of syphilis among clients
- Proportion of clients with RTI
- Quality and clarity of training materials (2)
- Reduced incidence rates of HIV/AIDS/STIs (4)
- Reduction in incidence of HIV/AIDS/STIs among military
- Reduction in incidence rates of HIV/AIDS/STIs. (52)
- Reduction in morbidity and mortality rate for children under five years.
- Reduction in mother to child transmission
- Reduction in rates of maternal and infant morbidity and mortality. (3)
- Reduction in rates of MTCT.
- Referrals made
- Referrals to contraceptive services
- Relevant information informs policy decisions
- Satellite clinic organize in red-lighted areas (2)

- Satisfaction with quality and relevance of training
- Shift in environment making it more comfortable for those most at risk, as well as the general population, to talk frankly and intelligently about HIV/AIDS/STIs (2)
- Significant policy and perspective shifts toward prevention and care (2)
- STI incidence
- STI prevalence
- Strengthened coordination at the national level
- Targeted youth survey to determine the café's impact youth in the area (2)
- Training of pharmacists, drug sellers, and health care workers, and expansion of private provider network for reproductive health services.
- Training sessions by type (6)
- Types of providers involved in interventions.
- Whether the program's messages were clear and compelling (2)

ANNEX 6: LIST OF BARRIERS AND ENABLING FACTORS

BARRIERS

1. Community, Culture, Religion

- A pronatalist tradition (2)
- Conservativeness of parents and teachers (2)
- Cultural
- Cultural and attitudinal
- Cultural and religious barriers
- Cultural attitudes, such as the low status of women, and some cultural practices that facilitate the spread of HIV/AIDS (2)
- Cultural barriers (9)
- Fear of religious backlash
- High level of stigma surrounds HIV/AIDS
- IDU as element of youth subculture (2)
- Lack of awareness on HIV/AIDS (2)
- Lack of information
- Lack of perceived threat of HIV in the E&E region
- Lack of support for prevention initiatives among some local community leaders (2)
- Lack of understanding of DP concept
- Male dominated culture
- Male-dominated, pro-natalist culture, reflected in low literacy and education levels for women (2)
- Myths about condoms
- Negative attitudes on condom promotion
- Opposition to condoms by some influential religious groups/ leaders
- Overall human phenomenon to focus on curative services rather than preventive.
- Pronatalist culture (2)
- Resistance from religious groups on the use of condom (2)
- Rumors, socio-cultural barriers
- Sex culture and attitudes to condom use
- Sexual cultural values (male domination)
- Sexual culture (4)
- Social beliefs opposing or attaching stigma to condom use and contraception (2)
- Stigma
- Stigma against condom use in marital context
- Stigma associated with condom use
- Stigma associated with HIV,
- Stigma attached to using condoms
- The stigma surrounding AIDS deters many people from seeking VCT (especially in rural areas where they fear they will be recognized) (2)
- Topics of sexuality politically sensitive to discuss in the media
- Visiting partners, low marriage rates weaken women's ability to negotiate condom use
- Widespread bias against both condoms and oral contraceptives stemming from various causes including religious objections, partner objections, and fear of side effects (2)
- Women having little control over sexual decision making (2)

2. Institutional

- Agents are not trained in BCC, currently provide basic information & referrals only.
- Agents can in some instances only provide condoms, have to refer to the clinics for the other contraceptives.
- Community-based agents are not allowed to prescribe STI treatment - loss of clients during referrals.
- Community-based agents in some sites are not allowed to distribute oral contraceptives
- Difficulty for FP providers in embracing new ideas and strategies

- Few materials for providers to develop skills
- Health centers are not given adequate supervision
- Health providers bias towards curative care
- Inadequate skills
- Inadequate supplies/ equipment
- Inconsistent availability of facility based care (2)
- Infrastructure (vertical services)
- Insufficient time for IEC
- Lack of adequate supplies (for example, STI drugs or the availability of VCT centers within reasonable distance for the clients) (2)
- Lack of capacity in FP partners to take on HIV/AIDS activities
- Lack of commitment (3)
- Lack of counselling materials/job aids on DP.
- Lack of effective supervision
- Lack of experience of providers to provide integrated health care (2)
- Lack of IEC materials for HIV/AIDS
- Lack of materials to support providers in their efforts (2)
- Lack of personnel (4)
- Lack of skilled people in HIV/AIDS
- Lack of staff commitment
- Lack of supplies and facilities (2)
- Lack of tools to help providers talk about DP
- Lack of trained staff (2)
- Limitations in supplies
- Management
- Many providers are not knowledgeable (have not received training) on HIV/AIDS related issues.
- Motivation of health providers
- Personnel
- Problems with communication between health centers in rural areas
- Program implementation in a traditionally FP setting
- Provider attitudes regarding male and female condoms
- Provider resistance
- Providers are not always comfortable talking about HIV/AIDS
- Providers conservative and reluctant to discuss sexuality with youth
- Providers don't have enough information about HIV/AIDS and how to counsel clients.
- Providers lack knowledge outside of their speciality
- Providers: cultural factors and lack of training, I.e. pharmacists uncomfortable with talking about HIV but freely discuss FP (5)
- Record keeping universally poor
- Reluctance to condom use by providers
- Research on proven best practices techniques often leads to over-burdening the service providers.
- Separated services
- Services could be improved by training all nurses in syphilis screening and treatment, and ensuring a steady supply of essential clinic supplies
- Services organization (2)
- Shortages of skilled human resources (5)
- Staff attitude
- Staff shortage
- Staff/services already overloaded so VCT seen as "one more thing to do"
- Tendency of health care providers to think within their own specialty which prevents them from embracing the idea of providing integrated services.
- Traditional role of family planning providers
- Trouble maintaining adequate supply of infection prevention materials
- Turn over of trained staff
- Unexpected additional activities, such as IEC in refugee camps.
- Unexpected additional activities, such as IEC in refugee camps.

- Weak training and supervisory systems of most CBD programs
- Workload of staff at some health facilities is quite high and prevents the staff from spending adequate time with their clients (2)

3. Financial / Economic

- Cost factors
- Currency devaluation in Brazil.
- Existing methods for screening for RTI among family planning clients are not cost-effective
- Funding
- Funding: limits SOW to include outcomes important to funder which places bias on one activity or another (5)
- Inability to pay for treatment due to poor economical condition;
- Inadequate funding to train all health workers (2)
- Insufficient funding for FP/RH commodities/ services; requires difficult GOK choices
- Limited funding
- Low per capita GNPs (2)
- Poor national economy and a dilapidated infrastructure (2)
- Poor resources
- Reluctance to commingle HIV and FP funds
- Specific resources should be dedicated to the maintenance of previous campaigns.
- Vertical nature of donor funding
- Weak purchasing power

4. Developmental / Environmental

- High fertility and maternal mortality rates (2)
- High HIV prevalence rate, resulting in economic and socio-cultural disruption, such as the disintegration of families (2)
- High TFR
- Lack of education among population (2)
- Lasting impact of 1994 genocide.
- Low levels of education (2)
- Mali's drought-prone climate gives rise to high levels of rural to urban migration (2)
- Military conflict and social unrest (2)
- Political instability.
- Poor social condition of clients
- Poverty
- Poverty and limited prospects for significant economic progress in the nation (2)
- Social suffering and economic underdevelopment as a result of a mature AIDS epidemic and periodic natural disasters, such as drought (2)
- Wars in region delayed program implementation (2)

5. Individual

- Attitude to condom use (2)
- Attitudes to condom use (4)
- Client resistance to using condoms
- Contraceptive ignorance (2)
- Denial of risk (2)
- Desire to have children (3)
- High desired TFR
- Inadequate awareness
- Most of the clients seen are women who have problems negotiating condom use with their partners.
- Perception of free condoms as lower quality
- Reluctance to condom use by clients
- Women who have been sterilized hesitate to ask husbands to use condoms (2)

6. Access and Availability of Condoms/Supplies

- Access to condoms
- Condom supply has been a challenge (2)
- Female condoms not easily available
- Inadequate supply of female condoms
- Occasional stock-out of condoms
- Shortage of condoms and STD drugs
- Shortage of drugs and supplies
- Shortage of supplies
- Shortage of supplies and logistics
- Shortage of supplies and logistics problem
- Shortage of supply
- Shortages of supplies
- Stock outs of contraceptives
- Stock-out reduction and monitoring at SDP level.
- Supplies limitations (2)

Other

- Age of consent (16) meant youth could not be officially provided with RH services under 16 years old
- Alternative sites for method provision and information
- ARVs when provision of routine drugs and supplies is very intermittent
- Commercial regulations and taxation practices that impeded condom distribution and accessibility.
- Contentious issues within GOK–e.g., begin charging for some public sector condoms? roles/ responsibilities (e.g., for procurement, promotion, logistics)
- Designing integrated messages
- Different collaborators / CA partners on the ground
- Different divisions with different mandates in MOH and policy bodies
- Different levels of political support for HIV/AIDS and FP interventions
- Difficult to involve males,
- Difficult to reach the high risk behavior people (2)
- Difficulty of involving males
- Entrenched vertical systems
- Few models of integrated care exist to show benefits and motivate providers
- Government crackdown on brothels has led to increase in indirect commercial establishments (2)
- Greater weight given to possibility of unintended pregnancy than of HIV infection
- Health facilities and pharmacy shops are located far from IDP settlement
- Highly vertical and specialised health systems
- Identification of sites that meet study implementation criteria
- Implementation of a series of activities to systematize stock-out control including the development, standardization, and dissemination of an LMIS.
- Incomplete population-wide data on HIV/AIDS incidence among CSWs.
- Integrating STI/HIV testing into FP service sites may discourage men from seeking diagnosis and treatment.
- Intensive promotion of condoms as HIV protection device in the country has stigmatized its use as a contraceptive device within marriage (2)
- Low literacy (3)
- Lack of access to media among population (2)
- Lack of connection between communities and their health services (2)
- Lack of existing baseline data on knowledge, attitudes and practices.
- Lack of existing data on HIV/AIDS (2)
- Lack of existing data on MTCT prior to PSI and partner initiatives.
- Lack of health infrastructure
- Laws that tend to permit official sales of condoms only in pharmacies, while high risk populations buy unsanctioned condoms of untested quality at kiosks (2)
- Limitations of syndromic management approach for vaginal discharge
- Little past experience

- Logistics
- Logistics of adding test kits
- Long lead time in study development and long
- Maintaining quality in all activities
- Male attitudes
- Male resistance among married couples (2)
- Male resistance on using condoms among married couples (2)
- Men do not like to use condoms (2)
- National and local laws limiting distribution of contraceptives.
- NGOs with strict agenda or only tech ability in one area (5)
- None
- Not enough VCT sites
- Political commitment
- Political, social, and legal barriers, including opposition to the promotion of condoms among some politicians and religious leaders, and legal barriers to the promotion of some other contraceptives (2)
- PSI's programs have already reached "early adopters." (2)
- Rejection from men
- Rejection from men to use condoms (2)
- Restrictions on information flow by military leaders means much data must be gathered anecdotally.
- Target populations have little access to media
- There is a need to be flexible to respond to district priorities
- Turf battles between different reproductive and child health programs in the MOH
- Weak data on HIV/AIDS (2)

ENABLING FACTORS

1. Commitment / Collaboration / Stakeholder Involvement

- An established PSI "platform" with long-term commitment to country. (47)
- Both FP and HIV prevention are priorities of district and mission, as well as health workers (2)
- Collaboration with IMPACT and Horizons sites
- Commitment (2)
- Commitment from NGOs to integrate HIV/AIDS donor commitments to HIV/AIDS integration
- Commitment of health managers and providers
- Community based trained quality teams
- Community mobilization and voluntarism
- Community outreach (2)
- Community support
- Conducive policy and programmatic directions (2)
- Emphasis on coalition and partnerships
- Engagement of young people in all phases and on all committees of project.
- Funding for multiple components from USAID
- Generally conducive policy and programmatic direction (4)
- Generally conducive policy direction
- Greater awareness
- Growing awareness and need by partner NGOs to address HIV/AIDS as a major issue
- High profile support for the program from the government of Vietnam (2)
- HIV protection for men increases motivation for condom use which in turn benefits women (4)
- Improving awareness
- Increased high-level political support
- Increased political support
- Increased understanding of value of dual protection among providers (2)
- Increasing Government support for condoms
- Involvement of religious leaders in the program
- Involvement religious leaders in the program
- Military's cooperation in BCC campaigns.
- Military's purchase and distribution of condoms.
- MOH has made HIV prevention a top priority.
- MOH has made HIV prevention and family planning top priorities.
- MOH support
- Multilateral support & popular demand
- Multiple donors and partners.
- Perceived need for broader range of services
- Policy and program directions
- Policy and programmatic directions (2)
- Policy direction
- Policy environment (7)
- Political will in Haiti to address MTCT.
- PRISM has been working with community leaders and groups with the formal health authorities and their partners to foster local ownership, management and leadership.
- Productive contacts with religious and cultural leaders, government, and NGOs (2)
- Progress in changing local and national laws limiting distribution of contraceptives (2)
- Public demand for more integrated, convenient services
- Recognition from many that it is becoming necessary
- Reproductive health coalitions
- Staff commitment
- Strong community network
- Strong GOK commitment to strengthen HIV prevention
- Strong political support (2)
- Strong support for GOK Condom Policy & Strategy from USAID/ Kenya, World Bank, DfID, and other donors

- Strong support of Central Board of Health to promote and institute real health reform focusing on integration (2)
- Support from donors and other NGOs/PVOs
- Support from government officials
- Supportive political climate, including high level of government advocacy
- Supportive political environment in Uganda
- Supportive traditional and religious leaders; orientation of young people towards dual protection.
- Synergy between program elements
- The existence of a national policy on integration (2)
- USAID priority given to DP studies
- Use of societal gatekeepers (imams, popular singers, sports figures) (2)
- Very supportive funder
- Willing and high enthusiasm of CBS workers
- Willingness of health workers to take on additional responsibilities (2)
- Willingness of providers to council on DP
- Women desire to prevent from unwanted pregnancies
- Young male peer educators and CBDs get more males involved in family planning (2)
- Zambian Integrated Health Package (ZIHP) government/NGO partnership (2)

2. Service Provision

- Ability to improve performance at the sites through an improvement in working conditions and in skills of service providers
- Active HIV/AIDS and FP programs
- Availability of technical and supervisory support (2)
- Clinic based education
- Clinic networks with integrated sites, I.e. providing products, counseling and other services (4)
- Clinic networks with integrated sites, I.e. providing products, counseling and other services
- Competency based training of providers
- Demonstration site is already providing integrated MCH/FP services
- Development of tools and training for providers to do integration
- Enthusiasm of providers
- Good physical facilities
- Growing provider awareness of STI epidemic and potential HIV explosion
- Guidelines which promote dual protection activities
- Has trained service provider (2)
- Health providers are capable of emphasizing preventive measures - changing individual behavior and promoting condom use.
- Increased access to good performance improvement materials--distance education, job aids, etc. (2)
- long tradition of reliable care
- On-site antenatal syphilis services are cost-effective
- Service provider competency based training
- Services reorganization
- Services reorganization
- Support in the improvement of logistics system
- Training
- Training
- Training (11)

3. Access

- Affordable, quality condoms widely available in the private sector
- Availability of World Bank loan funds to enable GOK to procure condoms
- Clients have access to contraceptives around the clock
- Condoms are easily available (2)
- Condoms are freely and readily available
- Condoms are inexpensive and widely promoted in the country, therefore they are known (2)
- Free availability of STI treatment at the clinics where clients are referred to by the agents.

- Good condom distribution in private sector outlets.
- Male condoms are consistently and easily available
- Providing sufficient method mix and services that allow for increased education and knowledge of use. (5)
- Support in logistics system
- Support in the improvement of logistics
- Support of the logistics system

4. IEC / BCC

- BCC should be combined with training and clinical services to be most effective.
- Consistent use of multiple media (TV, Radio, print, community) to promote integration with the same messages
- Educational materials
- Existing BCC channel can be used to increase the awareness level (2)
- Getting out information on several fronts through mass media
- Hotlines
- IEC (2)
- Intensive IEC/BCC programs (4)
- Outreach (3)
- Power of branding quality with recognizable symbols
- Use of radio messages (2)

Other

- Additional focus on social mobilization (paying attention to the demand side of the equation)
- Agents provide holistic services and hence are able to open doors for prevention and information activities on HIV/AIDS
- ARH program was integrated from inception
- Awareness in communities of the threat of HIV/AIDS
- Being perceived as an reliable and expert source in HIV/AIDS information and prevention
- Building on tools that existed for FP counseling and adapting them for DP.
- CBD workers view integration as challenging but helpful
- Close links between RH and HIV/AIDS, both at HQ and at Regional Offices
- Close relationship with community (2)
- Community-based agents provide integrated and holistic services to the communities, opening doors for the provision of dual protection activities.
- Development of youth counselling manual for providers
- Development of youth friendly centres and services for youth
- Easy access to the community (2)
- Established FP distribution system in public sector
- Experienced technical partners such as the Pan American Health Organization.
- Good supervisor.
- High erudition of the clients
- High level of knowledge and use of condoms in region
- High levels of literacy and television ownership make audience easy to reach
- High need for integration of STI case management and perception of need for prevention messages
- HIV/AIDS epidemic
- HIV/AIDS epidemic
- HIV/AIDS NGOs can provide trained counselors for information and referral booths.
- Implementation of STIs lab
- Integration of HIV prevention into family planning activities
- Interest among women in dual protection
- Layered campaigns (VCT, core transmitters, STD prevention) save resources and result in more focused and continuous messages
- Low current levels of HIV infection (though STI levels high) (2)
- Male counselors and male CBDs get more males involved in family planning
- MOH staff at this site rotate among FP, well child, antenatal, etc. services

- NGOs implement integration rapidly
- Orientation of young people towards DP
- Partner NGO already takes comprehensive approach to youth development: support to tean moms, home visits to new moms, income generation, school help
- Partnership with Vietnam Youth Union, the nation's largest youth-focused organization (2)
- Peer education (7)
- Peer promotion
- Phase I of PSI's project established a distribution system and began to destigmatize condom and other reproductive health topics (2)
- Power of the Quality Improvement Recognition Program's "Gold Star" concept
- Program collaboration with other NGOs and INGOs
- Project methodology allows for addressing of gender and social factors - integrated education and health approach gains trust with community
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- Referral systems
- Strong NGO and community-based sectors.
- Strong public sector HIV/AIDS program, including contact investigators;
- Supervision (10)
- Targeting youth groups with concern for both STI and unwanted pregnancy (5)
- Technical skills and entrepreneurial approach of PSI staff. (55)
- Use of peer educators (2)
- Use of private sector distribution networks to promote products and services. (60)
- We work with young couples (15-25) most of whom are reluctant to use pills as a contraceptive device. They are more willing to use condoms or abstinence (2)